

<b>Case Number:</b>	CM14-0170765		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	10/19/2012
<b>Decision Date:</b>	12/03/2014	<b>UR Denial Date:</b>	09/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in Montana. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a janitor with a date of injury of 10/19/12. The medical records indicate that she developed pain in the low back, neck and shoulders related to work activities. She was initially seen by her primary care provider and referred to orthopedics. Treatment has included nonsteroidal anti-inflammatory drugs, pain medication, physical therapy, acupuncture, massage and epidural steroid injections. She would have arthroscopic surgery on the right shoulder on 3/18/14 and decompressive surgery is recommended for the left shoulder. Electrodiagnostic testing would confirm bilateral carpal tunnel syndrome and bilateral ulnar neuropathy at the elbows. She continues to have complaint of pain in the bilateral shoulders, neck and low back with radiating pain, numbness and tingling in both upper and lower extremities. Her primary treating physician has requested cold therapy device for purchase.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Cold Therapy for Purchase:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder, Continuous-flow cryotherapy

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Continuous-flow cryotherapy

**Decision rationale:** The MTUS does not specifically address cold therapy devices. The ODG guidelines recommend continuous-flow cryotherapy as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. Complications related to cryotherapy (i.e, frostbite) are extremely rare but can be devastating. In this case the request for purchase of the cold therapy unit is not consistent with the ODG guidelines and is not medically necessary.